

Factors Influencing Gender Disparities in the Prevalence of HIV/AIDS in Fako Division Cameroon: Case Study of Limbe and Buea Regional Hospitals

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ABSTRACT

There is a prevalence of HIV/AIDS in the society among men and women and there is gender disparity in the prevalence of HIV/AIDS. Biological and other factors are pointing to the fact that the women are more vulnerable and therefore have more possibilities of spreading it. This study was done in Fako Division in the South West Region of Cameroon. The general objective of this study was to investigate the factors leading to the gender disparity in the prevalence of HIV/AIDS. The research is a descriptive survey. The target population was the HIV/AIDS patients that are treated in the Limbe and Buea Regional Hospitals. These hospitals were purposively selected with a purposive sampling of 50 males and female. This research involves the use of both primary and secondary data with the use of questionnaires, check list and review of secondary data on problems leading to a gender difference in the prevalence of HIV/AIDS in these areas. Analysis of data was done with the use of windows SPSS. Findings of the study show that there is a high gender difference of about 39.21% in Buea Regional Hospital and a gender difference of 24.4% in Limbe Regional Hospital. Some factors were found responsible for this disparity that include early start of sexual activities for females, low level of education, multiple sexual partners, unemployment for females and others. Recommendations have been made to the government, the women themselves, health professionals, NGOs and other significant stakeholders.

KEYWORDS: Gender, HIV/AIDS, Pandemic and vulnerability

DEFINITION OF KEY WORDS

HIV/AIDS: This is an immune disease caused by a virus called the human immune virus. This virus invades the human body and takes over cell activity and invades the body there by reducing the body's ability to fight against some infection (opportunistic infections)

GENDER: As a noun it is defined as the biological sex of an individual (usually male or female). A socio-cultural phenomenon that divides people into various categories such as male and female into which sexually –reproducing organisms are divided according to their reproductive roles each having associated dress roles, stereotypes etc. As a verb according to sociologist; to assign to someone else a gender. To perceive someone as having a gender. According to archaic to breed or engender.

DISPARITY: A state of being unequal; a difference, an incongruity; an instance or point disagreement, dissimilarity; a discrepancy; an inconsistency

PANDEMIC: Epidemic over a wide geographical area and affecting a large proportion of the population. A pandemic disease is one that hits a wide geographical and affects a large proportion of the population.

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VULNERABILITY:

Susceptibility to attack or injury; the state or condition of being weak or poorly defended. A specific weakness in the protection or defenses surrounding someone or something.

1. INTRODUCTION

HIV/AIDS continues to spread rapidly: among the 33.6 million cases of people living with the virus at the end of 1999, one in six were new infections acquired during the previous 12 months and there were 2.6 million deaths (including half a million children) that year. It now causes more deaths than any other infectious disease, having overtaken TB and malaria. It is the fourth biggest killer in the world (after heart disease, stroke and respiratory diseases) and has become the single largest cause of death in Africa. Across the world, there has been a changing pattern of male/female infections. Early cases in many countries were concentrated in male homosexuals and intravenous drug users, but as the epidemic has spread there has been a progressive shift towards heterosexual transmission and increasing infection rates in females. The reality today is that, globally, more women than men are now dying of HIV/AIDS, and the age patterns of infection are significantly different for the two sexes. (Matlin S and Spence N, 2000).

The HIV pandemic disproportionately impacts young women. Worldwide, young women aged 15–24 are infected with HIV at rates twice that of young men, and young women alone account for nearly a quarter of all new HIV infections. The incommensurate HIV incidence in young – often poor – women underscores how social and economic inequalities shape the HIV epidemic. Confluent social forces, including political and gender violence, poverty, racism, and sexism impede equal access to therapies and effective care, but most of all constrain the agency of women. (Eugene RT, Sear EC, Tiffany K et al, 2014).

HIV disproportionately affects women and adolescent girls because of their unequal cultural, social, and economic status in society. Gender inequality, intimate partner violence, and harmful traditional practices reinforce unequal power dynamics between men and women. This limits women's choices, opportunities and access to information, health and social services, education and employment. Stigma and discrimination, as well as inequitable laws and cultural practices, further exacerbate women's vulnerability to HIV and undermine the response to the epidemics. (AVERT 2016).

While it has long been recognized that men and women face unequal risk to HIV infections, explanations for the sources of gender differences in risk remain relatively weak. In some major world regions gender disparities appear to be widening such that women make up a growing proportion of persons living with HIV (UNAIDS 2007).

Women are disproportionately affected by human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) in sub-Saharan Africa (SSA). The determinants of gender inequality in HIV/AIDS may vary across countries and require country-specific interventions to address them. This study aimed to identify the socio-demographic and behavioral characteristics underlying gender inequalities in HIV/AIDS in 21 SSA countries. (Drissa S, Yentema O, Mohamma H et al, 2016).

The HIV virus can be transmitted through various means and affects both women and men but not at the same rates. It is been seen from the prevalence of this disease that women are more affected by this disease than men, which means women are more vulnerable to this disease than men.

There is a prevalence of HIV/AIDS in the society among men and women but there is disparity which is a call for concern. History and biological factors show that the woman is more vulnerable to this disease and has more possibilities of spreading it. Therefore this is a problem to the society because it has effects on the economic, social and other areas and levels in the society. We need to know why women are more infected and how this high infection rates can be reduced.

1.1. OBJECTIVE OF THE STUDY

The general objective of this study is to investigate and highlight the factors that lead to a gender disparity in the prevalence of HIV/AIDS and specifically come up possible measures that can be taken to remedy the problem. In terms of significance, this paper will help to create awareness among young men and women on their vulnerability to HIV/AIDS, show the unequal chances of being infected that

exist between men and women, and help to reduce the prevalence of HIV/AIDS as many women will be aware and more careful in the management of their reproductive health. It will also help health personnel to better teach patients during birth control sessions on how to protect themselves and make them understand how vulnerable they are.

The government of Cameroon and other development institutions and stakeholders alike NGO 'S and CSO'S will know how to integrate gender (how to consider both men and women) to eradicate the high gender disparity and its socio-economic effects in the society.

2. LITERATURE REVIEW

In this study literature shall be review on the conceptual framework of gender disparity in the prevalence of HIV/AIDS, under the following headlines, gender disparity in the prevalence of HIV/AIDS, the causes, and possible majors to curb this gap that exist.

2.1. TRENDS IN THE GENDER DISPARITY IN THE PREVALENCE OF HIV/AIDS

According to BMC Public health in 2016 there were three distinct patterns. First, in the majority of countries, the response effect (the differential effect of a risk factor on women and men) explained the concentration of HIV/AIDS among women; the percentage of the gender inequality in HIV/AIDS attributable to this component ranged from 81.5 % in Mozambique and Rwanda to 116 % in Congo Brazzaville. These results indicate that, had responses to HIV/AIDS risk factors been equivalent for men and women, the prevalence of HIV/AIDS would have been 19 % lower among men relative to women in Mozambique and Rwanda and 16 % higher among men relative to women in Congo Brazzaville. Second, in Uganda and Ghana, the composition effect (i.e., difference in distribution; the differential distribution of risk factors by gender) explained 84 % and 92 % of the higher prevalence of HIV/AIDS for women compared to men, respectively. Third, in Cameroon, Guinea, Malawi and Swaziland, both response and composition effect explained gender inequalities in HIV/AIDS prevalence. More than one-half of the gender inequality in HIV/AIDS prevalence in these countries was attributable to gender differences in responses to socio-demographic characteristics, sexual behaviors, HIV/AIDS awareness, and unmeasured risk factors. There are gender inequalities in the prevalence of HIV/AIDS in SSA (Sub-Saharan Africa) across countries. Analyses showed that women had a higher prevalence of HIV/AIDS than men in at least three-quarters of the countries surveyed. Furthermore, a comparison of gender inequalities within countries surveyed on two occasions since 2003 suggests that these inequalities are persistent over time. Consistent with earlier work, results showed that gender inequalities in HIV/AIDS prevalence were larger in magnitude in countries with a greater burden of HIV/AIDS, particularly countries situated in south-east SSA, including Malawi, Mozambique, Swaziland, Zambia, and Zimbabwe. (Drissa S, Yentema O, Arijit F et al, 2016).

HIV/AIDS is a significant and worsening health, economic, and social issue in Sub-Saharan Africa (SSA). Africa's share of the global pandemic is very high Of Africa's 23.0 million adults living with HIV/AIDS, 13.2 million are women, constituting 77% of the world's women with HIV/AIDS (data

for end-2003 UNAIDS). Africa is the only continent where HIV prevalence is higher for women than for men. Women account for the majority of adults (57%) living with HIV/AIDS. The aggregates mask key age/sex differences in HIV prevalence. For every 15-19-year-old boy who is infected, there are five to six girls infected in the same age group. The trends in age/sex differentiated prevalence rates

for people aged 15-24, as revealed in the data for end-2001 UNAIDS, suggest that the situation for young women has worsened considerably in most countries over this period, while the situation for young men is more mixed. On this evidence, Africa is losing the fight to protect its youngest and most vulnerable women from the scourge of HIV/AIDS. (Nsagha DS, et al. 2010).

HIV-1/HIV-2 co-infection among voluntary counselling and testing subjects at a regional hospital in Cameroon (Nsagha DS, et al. 2010)

Overall HIV sero-prevalence in the study population

HIV sero-status	Males	Females	Total
	No (%)	No (%)	No (%)
Number of positive cases	21 (26.9)	57 (26.9)	78 (73.1)
Number of negative cases	59 (27.8)	153 (72.2)	212 (100.0)
Total	80 (27.6)	210 (72.4)	290 (100.0)

From this table which is a studies carried out by Nsagha DSet al in 2010 in regional hospitals in Cameroon we can clearly see that the prevalence among women is more than that among men which shows a gender disparity in the way HIV/AIDS pandemic is spreading.

2.2. FACTORS LEADING TO THE GENDER DISPARITY

Addressing issues of cause's women, gender, and health requires the study of the health of women / girls and men/ boys - throughout the life course, with gender, gender equality, and biology understood as important and interacting determinants of well-being and disease. Also included are the study of gender and gender inequality in relation to individuals' treatment by and participation in health and medical care systems, the physical, economic, and social conditions in which they live, and their ability to promote the health of their families, their communities, and themselves. Inherent in this definition is recognition of diversity and inequality among women - and men - in relation to race/ethnicity, nationality, class, sexuality, and age, and that protection of human rights is fundamental to health. (Awuba and Macassa, 2007)

A. SOCIO ECONOMIC DETERMINANT

Socioeconomic determinants are those which can act both directly and indirectly on HIV/AIDS prevalence rate by creating an environment that favors risky situations and that do not always allow to take advantage of the whole information available. These are poverty (both at individual and at national level), income inequality, education level, urbanization, mobile population and access to information.

B. NATIONAL INCOME:

Worldwide, fist HIV/AIDS cases have been discovered in developed countries, but the epidemic spread the fastest in poor countries. The main reason for this discrepancy is that developed countries could implement prevention measures and care for sick people, thus decreasing their infectivity and by then the number of new infections. This negative association between income especially among women and HIV prevalence at national level reflects the role that better infrastructure, access to health services and nutrition seem to play in the spread of the disease.

C. POVERTY (AT HOUSEHOLD AND INDIVIDUAL LEVEL):

Poor households typically have few financial or other assets and are often politically and socially marginalized. These conditions of social exclusion increase the problems of

reaching these populations through programmes aimed at changing sexual and other behaviors (Cohen, 1998). Thus they tend to lack adequate information. Poverty also impacts on HIV transmission through less access to health services. Moreover, as noted by Stillwaggon (2002), people are also biologically more vulnerable to HIV infection when they are malnourished and/or experience parasitic infections (that weakens immune system), two features that are more prevalent among poor people. Finally, when poor people are aware of the infection, they are not able to protect themselves and are more likely than others to engage in risky behaviors such as migrant work and commercial sex work.

D. INCOME INEQUALITY:

Amongst men and women in addition to their low income, African countries are characterized by unequal income distributions. Researchers in other fields have placed socioeconomic inequalities at the center of their analysis (Farmer, 1999; Rao Gupta, 2002 and 2006). Income inequalities place a big part of population in risky situations, since they are less able to protect themselves, even when they are aware of the risk of infection. Income inequality does also cause rural exodus, as there is usually a significant difference in living standards between big cities and villages in Sub-Saharan Africa. In addition, for the same income level, a country with more income inequality is likely to have a higher prevalence rate because a greater part of population does not have access to basic services as education and health. HIV/AIDS prevention activities are based in health facilities and infected people need to know about their infectivity status (through testing) in order to prevent further infection in their partners. In poor countries where ART is already available but not offered free, poor people cannot afford its cost and will thus remain highly infective.

E. INADEQUATE EDUCATION:

One of the key determinants of the infectious diseases is education level. At the onset of epidemic in sub-Saharan Africa, the virus affected people regardless of their education level. Actually limited education can be a factor that exposes them more to virus infection, as it goes hand in hand with higher socio-professional category. Indeed, those people

from high socio-professional categories (especially men) travel more than others for work and are more likely to support a “second office”, given their higher income. Over (1997) found a positive socioeconomic gradient in the HIV/AIDS epidemic, as also did Lachaud (2007), using data from Burkina Faso. However, as the epidemic spread out the proportion of infected people among educated people is expected to be lower than in the rest of the population. This can be due to many reasons; first, educated people are better informed about prevention measures. Like access to health care, access to education is a means of being informed on prevention methods, especially if educative programs include sexual education. Sensibilization is widely done on the radio and through posters. The fact that a large part of population can read and speak the official language(s) spares them misinterpretations due to translation errors. Also, since infected educated people are no more productive at the onset of sickness and will not be able to perceive an income, education increases the opportunity cost of being infected. Last, education impacts on HIV/AIDS prevalence by delaying age at the onset of sexual activity, especially in regions where girls are sent into marriage as soon as they abandon schooling. (Couderc and Ventelou, 2005).

F. INFECTIONS THROUGH MOBILE POPULATION

Migrant workers form an important part of labor force in poor countries. Industrial and mining projects are almost located in remote areas where workers cannot see their regular partners for a long time. Commercial sex develops in these areas for economic reasons. Generally, neither sex workers nor their clients are aware of their serologic status. Then both incoming population (workers will infect their regular partners once back at home) and welcoming population (sex workers will infect their occasional and regular partners when migrant workers will leave the area) are affected by the epidemic. Rural exodus has the same effects on young people going to big cities and looking for a job there.

Vii ACCESS TO INFORMATION:

Many infections occurred because people were not even aware of the virus existence and most still occur because they are not informed appropriately about transmission modes and preventive measures. While awareness of the epidemic is on the rise, specific knowledge about HIV is still inadequate. Although efforts are increasingly made to sensitize populations and especially young people about the pandemic, there are persistent misconceptions about how HIV is transmitted; meanwhile, these people constitute the age group most exposed to the infection. AIDS awareness is still far from universal. From this view, information is of great importance to slow down and stop the pandemic. Information and education have a synergic action; information campaigns are mostly delivered in the form of posters display, advertising messages on the radio and television, generally in the official language that can be different from local ones. In the 2001 Demographic and Health Survey from Cameroon, the percentage of respondents aged 15-19 who knew that a healthy-looking person can have HIV varies from 74% of girls (68% of boys) still at school to 55% of girls (48% of boys) no longer at school. The figure is of course worse among young people who have never been at school (17% of girls and 9% of boys). In fact, none of the 18 countries in which young people were surveyed by the Demographic Health Survey/AIDS indicator survey between 2001 and 2005.

G. NUTRITION STATUS AND INFECTION:

Interactions between HIV/AIDS and nutritional status can be observed at biological level as well as at the socioeconomic level. The weakness of immune system is one of the direct consequences of malnutrition. In her comparison of pandemic's determinants in Sub-Saharan Africa and in Latin America, still wagon suggests that population's nutritional status could be the most important factor of the epidemic in Latin America. She reminds that HIV/AIDS is an infectious disease before all and that its pandemic dimension should not make people forget that determinant variables for infectious diseases transmission are still relevant for HIV/AIDS transmission. Malnutrition and parasitical diseases are endemically spread in poor countries and it is well known that they weaken body's immune function. For instance, vitamin A is important for epithelial integrity, which plays a determinant role in STI protection, especially those ulcerative that make virus transmission easier. Thus, they would then be determinant in the pandemic evolution. Nutritional status also acts as transmission canal between poverty and the infection; food insecurity leads to risky behaviors such as seasonal migrations or sex work, strategies people use to diversify their income (stillwagon, 2006). 2005 had knowledge levels exceeding 50% (UNAIDS 2006).

H. POLITICAL DETERMINANTS

Some are closely related to governance, gender discrimination and access to health care services

➤ GOVERNANCE:

Its influence on the epidemic goes through the priority government gives to HIV/AIDS as a public health issue of concern. For most African countries, disastrous economic situation is caused more by bad governance than by international adverse conditions. In a corrupted political environment, decision-makers can be not incited to invest enough in HIV/AIDS prevention activities. In that way, good governance appears as a factor of the epidemic's slowing down. For Bonnel (2000), the politico-legal climate, which determines health expenditure, is among the catalysts of the epidemic.

Governance can also influence HIV/AIDS epidemic through the implementation of national programmes for the fight against HIV/AIDS (which plays a major role in countries like Cameroon) or the role of institutions (like in Uganda).

➤ GENDER DISCRIMINATION:

Gender discrimination can be considered as the unfavorable situation in which women are placed for the same conditions as men. They both cause and are caused by the lack of empowerment of women. There are many ways in which gender discrimination influences the evolution of the pandemic. First, women cannot always negotiate conditions in which sexual intercourse will take place, like condom use, even if there is certainty about the partner infection with HIV. In many countries, laws do not allow women to inherit land or to open bank accounts without their husband's permission. They do not have the legal and/or financial means to be autonomous and are submitted to men's economic power. Their unfavorable position is the basis of prostitution, which appears for them as the only source of income. Bringing a form of economic independence to women would reduce prostitution by increasing its opportunity cost. On a strict biological basic, the risk of

contamination from an infected man to an uninfected woman is three times greater than the risk of infection from an infected woman to an uninfected man.

➤ ACCESS TO HEALTH CARE:

AIDS-infected people are likely to experience more illness episodes, they will logically be in contact with health services more often. Meanwhile, access to health services increases the likelihood that sexually active people could seek care for STIs or visit health facilities in order to get tested. A valid instrument for this variable would represent access to health care at best, without being correlated with HIV prevalence rate. We used immunization rate as a first instrument, since immunization occurs only at health facilities, but on babies so that it has no correlation with adult HIV/AIDS prevalence rate. The second instrument used is the ratio of private to public health expenditure. The sum of the denominator and the numerator of this ratio is the value of our endogenous variable (health expenditure per capita), so they are strongly correlated. However, the structure of health expenditure in countries composing our sample is unlikely to have changed due to the epidemic. (Barroso Schechter, Cerbino- Neto J. et al., 2003).

I. SOCIOCULTURAL DETERMINANTS

Socio-cultural variables are also both direct and indirect. What makes them different from the previous group is that they rather influence people's behavior. These are some cultural and religious practices, average age at the onset of sexual activity, ethnic diversity and conflicts. Religious and cultural practices can favor the epidemic through age of the onset of sexual activity. Girls are generally sent into marriage during adolescence and age difference between partners is also generally high, another cofactor of virus transmission. Christian and Muslim religions on the contrary would have a negative impact on the course of the epidemic through delayed age at the onset of sexual activity due to religious education. However, the religious and traditional practice that has been proved to have a greater impact of HIV transmission is male circumcision and genital mutilation for that is wide spread in Africa. Cultural, social and economic pressures make women more likely to contract HIV infection than men. Women are often less able to negotiate for safer sex due to factors such as their lower status, economic dependence and fear of violence. (Auvert et al., 2005).

J. USE OF CONDOM:

As for Condom use, HIV/AIDS is transmitted through sperm, vaginal secretions and blood. Even in the absence of any ulcerative STI, a non-protected sexual intercourse can lead to virus transmission between individuals. Latex condoms provide protection against HIV transmission to both partners and reduce the impact of cofactors such as genital ulcers and other STDs. Thus, WHO recommends condom as the only contraceptive that also protects from HIV/AIDS when used efficiently. The Centre for Disease Control and Prevention (CDC, 1999) warns that only latex or polyurethane condoms provide a highly effective mechanical barrier to HIV. Moreover, for condoms to provide maximum protection, they must be used consistently (every time) and correctly. Pinkerton and Ambramson (1997) go as far as assessing the effectiveness of inconsistent condom use at 79% and that of consistent use at 90 to 95%. (UNAIDS, 2006)

K. GENITAL MUTILATION:

Male circumcision, which is common to many African customs and compulsory in Muslim religion, has a

demonstrated impact on HIV transmission but women's genital mutilation problem is more serious This practice consists of the prepuce removal for young boys. There are two potential reasons justifying the negative relationship between circumcision and HIV/AIDS infection. First, the prepuce's presence exposes men to HIV/AIDS infection due to potential tearing during sexual intercourse; in addition, it exposes them to STIs that are cofactors of the epidemic (Halperin et al., 1999). The ANRS 1265 randomized controlled trials in South Africa concluded to a reduction in the likelihood of female-to-male sexual HIV transmission by 60%, attributable only to male circumcision (Auvert et al., 2005).

L. ETHNIC DIVERSITY:

The degree of ethnic fragmentation is typically an environment variable. It would affect HIV/AIDS prevalence rate essentially through economic growth. Numerous economic works point out the negative relation between ethnic diversity and growth, namely those of Easterly and Levine (1998). According to them, ethnic diversity tends to make cooperative solutions more difficult to obtain in case of divergence. That would also be the case for a consensus on the portion of public spending allocated to the fight against HIV/AIDS. A big number of ethnic groups lowers confidence between economic agents and raises transaction costs. (Collier, 1998) points out that impact of ethnic diversity on growth transits through economic policy choices and then notes the importance of political institutions.

M. MULTIPLE SEXUAL PARTNERS AND MARRIAGE AND POLYGAM

There is a large difference in attitudes towards men's and women's sexuality before or outside marriage. Promiscuity in men is often condoned and sometimes encouraged, while it is usually frowned upon in women. One of the consequences of this gender difference is that men expose themselves to an increased risk of infection by having multiple partners, and in turn become the vector for transmission of HIV/AIDS to their partners, even if the women themselves are not behaving promiscuously. (Spiegel P, Harroff-Tavel H, 2006).

Marriage has influenced the transmission of this infection in that since men seem to be more promiscuous than women, in a marriage relationship the man may have other sexual partners which the woman does not know about and this brings a chain of sexual relationships which can lead to the transmission of this infection if any of the partners in this chain is infected. The woman is at weaker edge because she has the lower decision making power especially in negotiating the use of the condom to protect her and so is more exposed to this infection. For polygamous homes there is also a chain of sexual partners that is the man and is many wives. All of this people in this chain share infections from one wife to the husband and from husband to other wives, there are many women but just one man. This places women at a position of not being able to protect themselves from this infection. Couderc N., Ventelou, B. (2005).

N. BIOLOGICAL FACTORS

➤ AGE AT THE ONSET OF SEXUAL ACTIVITY:

This variable is thought to favor the epidemic mainly through girls' age at the first sexual intercourse. The younger they begin sexual activity, the more they are exposed to tearing, since their partners are almost always older and their body is still immature. More importantly, many people

aged less than 15 have not received enough formal sexual education to use condoms. This sexual education is rather learned in the street, with all what it embodies as misinterpretations and generally accepted ideas. People who engage early in sexual activity are thus less likely to protect themselves or to do so adequately.

➤ **HORMONAL CHANGES:**

Studies in animals have shown that the vaginal lining is thinner closer to menstruation, which suggests that menstruation is a time when a woman is more vulnerable to HIV infection. (Tsafack C, 2009).

➤ **SEXUALLY TRANSMITTED INFECTIONS:**

Sometimes women’s vaginal bacteria changes, lowering the levels of normal flora and increasing harmful bacteria, which can increase the risk of HIV infection 2.5 times. . Men’s and women’s risks of acquiring HIV escalate in the presence of Sexually Transmitted Infections (STIs). STIs in women are less noticed and often go undiagnosed. The stigma of STIs in women also presents a barrier that discourages them from accessing adequate treatment. (Bouhnik et al., 2002).

➤ **IMMATURE CERVIX:**

Women under 18 may not have a fully developed cervix. This means that the thinner cells lining the cervix are also found further down into the vagina. Since this layer is thinner, HIV is able to penetrate the vaginal wall easier in younger women than in older ones. (Dodds et al., 2000).

➤ **PREGNANCY:**

Pregnant women may be more at risk for HIV due to higher levels of hormones and changes in the immune system that protect the fetus. (Moatti and Kazatchkine, 2001).

2.3. SOME POSSIBLE MEASURES TO ERADICATE THE PREVELENC

There need to be an emphasis on the need for special efforts to be made to protect women and girls exposed to the risk of HIV/AIDS can be ensured that the legal, civil and human rights of those affected and infected are protected and that women have access to treatment, counseling and support on an equal footing with men, through school system, the labour market and government policies and strategies through health services and others. (Matlin and Spence, 2000)

A. FIGHT AGAINST HIV/AIDS THROUGH THE LAW AND HUMAN RIGHTS DURING NATIONAL PEACE AND CONFLICT MANAGEMENT

HIV/AIDS is exacerbating the difficulties that women face, when they or their partner becomes HIV-positive, and may make it difficult for them to exercise their rights to their property, employment, marital status and security. (Matlin and Spence, 2000)

Strategies for action (Joint United Nations Program on HIV/AIDS,1999)

- Urgent review is needed in each country of the legal status of women, to ensure that they have full and equal rights compared with men and that the protection of the law extends to those who become infected, orphaned or widowed as a result of HIV/AIDS.
- Sensitisation seminars and workshops are needed for the legal profession and law enforcement officers to

ensure that the legal provisions for equality are fully implemented.

- New laws may need to be enacted that deal with specific problems raised by HIV/AIDS, such as: legal sanctions against persons knowingly infecting others; rights to confidentiality; protection of employment, sickness benefits and pension rights.
- Review is needed of laws relating to the status of commercial sex workers and homosexuals.

B. REPORTS ON HIV/AIDS IN SITUATIONS OF CONFLICT AND INTERNAL AND EXTERNAL DISPLACEMENT OF POPULATIONS

In situations of conflict, the perpetration of sexual violence by soldiers on women and girls is therefore not only a criminal act but now also poses a very serious threat to life. Moreover, even in non-violent situations and where peace-keeping troops are deployed, ‘consensual’ sex with soldiers may be engaged in by those who are hungry, dispossessed or concerned with the survival of their families and dependants. (Kaufman, D., Kraay A. et al 2003)

Strategies for action:

- Education and training for soldiers that emphasises their own vulnerability to death from HIV/AIDS and discourages a ‘culture of recklessness’ which favours unprotected intercourse with sex workers and acts of sexual violence.
- Nationally and internationally, promote respect for human rights by soldiers, through combination of training and enforcement of severe penalties for infringements.
- Provide training in gender, HIV/AIDS and Human Rights for key planners and decision makers involved in post-conflict stabilization, and for national and international media representatives working in these situations.

Include reproductive health services as an essential component of humanitarian assistance in situations of conflict and displaced populations.

C. EDUCATION STAKEHOLDERS AND SCHOOLS

Advocate for improved health education and public awareness and the adoption of all measures that will limit the transmission of the virus including safe sex (increased use of male and female condoms), monogamy and abstinence as appropriate and the use of safe blood products. Preventing transmission may include effective sexual and reproductive health education⁵ aimed at changing behaviour, built into a broader, comprehensive approach of Health Promoting Schools. (Garbus L,2001.) As well as giving emphasis to the positive roles that schools can play in helping learners and teachers to cope with the issue of HIV/AIDS, it is important to recognise that schools do not always represent safe environments, particularly for girls. A number of aspects of the school organisation and environment need to be addressed to reduce risk:

- Safe transport to and from school for female pupils and teachers
- Safe school environments that avoid the possibility of sexual abuse or assault by other pupils, school staff, or unauthorized visitors to the school precincts
- Prevention of sexual relationships between staff and pupils, whether resulting from abuse or exploitation or as a means of obtaining financial or academic reward

- Children attending boarding schools may be particularly vulnerable (Collier, P., 1998.),

Schools also have important roles to play as focal points for the community. Teachers, parent-teacher associations and governing bodies often command a degree of respect and authority that can be used to advantage in mobilising community action. Local strategies need to be developed that draw on these resources and supplement them by collaborations with NGOs - including women's organizations - and the private sector to mobilise action. (Arndt C. and Lewis, 2000).

D. FINANCIAL AND OTHER ECONOMIC MEASURES
Solutions to HIV/AIDS prevalence could be targeted through the labour market.

The rates of employment of women in the formal economy are generally lower than for men, since they are often engaged in subsistence farming as well as in their domestic and reproductive roles. However, recent data shows that women now comprise an increasing share of the world's labour force - at least one third in all regions except North Africa and Western Europe. In addition, the informal sector is a larger source of employment for women than for men and is growing. Becoming seropositive often has a disproportionate economic impact on women compared with men. They are more likely to lose employment in the formal sector (in fact, self-employment can have positive advantages in resilience for women who become infected) and to suffer social ostracism and expulsion from their homes. When they are forced to become the main breadwinner due to their partner becoming infected, women lacking education and skills may be forced into hazardous occupations, including sex work, that further increase their vulnerability. (Bloom, D. E. Mahal A, 2001.),

Positive strategies to assist women who are affected by HIV/AIDS might include the encouragement of informal sector entrepreneurship and micro-credits, as well as community action groups and social welfare support mechanisms. (Blundell R., Bond S, 1998.),

E. THE YOUTH WINGED OR NATIONAL YOUTH MACHINERY

HIV/AIDS prevalence among young women can be checked through youth groups or national youth machinery.

In many of the heavily affected countries, young people represent the most rapidly growing component of new HIV/AIDS infections, with girls outnumbering boys by a substantial factor. The reasons for this vulnerability include factors relating to poverty, lack of information, lack of economic and social empowerment, and lack of availability of protective methods. Youth participation in programme planning, implementation, monitoring and evaluation

- Provision of youth friendly services and centres where young people can access information, support and referral
- Parental involvement in giving better communication, guidance and support to youth
- Promotion of skills-based education about HIV/AIDS
- Protection of girls and women against sexual abuse and exploitation and sensitisation and education of boys and men about their sexuality and behaviour

- Establishment of networks for young people, including those living with HIV/AIDS, for prevention, protection of human rights and promotion of acceptance by society
- More commitment and more responsible decision-making by young people themselves about their sexual behavior and influence on peers.

Engaging youth in addressing the epidemic has become essential. With the addition of the appropriate gender-based analysis and perspective to each of the above priority areas, they provide a sound basis for a youth-centred approach to combating HIV/AIDS. Initiatives such as the Commonwealth Youth Programme 'Ambassadors for Positive Living' have demonstrated that peer counseling, including that by young people living with HIV/AIDS, can have a power effect. (Arellano M., Bond S, 1991),

F. GOVERNMENT AND HIV/AIDS HEALTH SERVICES
The Government can fight against the prevalence of HIV/AIDS through its health services

It is now widely recognised that gender-based inequalities in the treatment of women and men permeate health systems in all parts of the world and this situation is mirrored in the specific area of HIV/AIDS. Examples can be found of gender biases in women's access to services for diagnosis, counseling and treatment; in the training of health professionals and their responses to patients; in the nature and focus of research into new drugs and treatments, including the greatly disproportionate use of men as research subjects to establish the pharmacological effects and efficacy of drugs. (Bouhnik et al., 2002).

Redressing these biases is not simple. Countries have been struggling for years with health sector reforms in response to a variety of external and internal forces, including structural adjustment, globalisation, economic contraction and shrinkage of state support for the social sector. In health systems that were previously fragile and are now being stretched far beyond their limits by the pandemic, the use of the meagre resources available in a cost-effective and equitable way requires a systematic and comprehensive new approach. (Audibert M., Mathonnat J2000)

To look on the positive side, this very crisis in the health sector, which is demanding a major re-think about priorities, now affords the opportunity for a new approach built on principles of evidence-based treatment and services and equality of access. The first step along this road must be the sensitization of senior health planners, managers and service providers, to create a willing and supportive environment for the necessary reforms leading to gender equality in the health sector. Leading on from this must be action to ensure that women and girls have adequate access to sexual and reproductive health services and that there is equality in the provision of drugs for treating HIV/AIDS and opportunistic infections and of palliative care, (Over M, 1998).

➤ THROUGH INTERGRATION OF GENDER (CONSIDERING DIFFERENCES BETWEEN MEN AND WOMEN) IN INTERVENTIOS MECHANISMS.

- Encourage the collection, analysis and use of sex-disaggregated data in all sectors and at all levels.
- Monitor the progress of HIV/AIDS in their countries, including its specific impact on women and girls.

- Liaise with and support the work of the National Commissions for HIV/AIDS in coordinating the fight against the disease across all sectors.
- Strengthen national capacities for gender analysis and planning through improving the use of sex-disaggregated data, development of gender-sensitive indicators and creating training tools and capacities in local institutions.
- Encourage the incorporation of systematic gender mainstreaming approaches in all sectors through the insertion of machineries and processes, such as Gender Management Systems, which ensure that continuing attention is given to gender issues in addressing HIV/AIDS, (Rao Gupta G,2002).

3. METHODOLOGY OF THE STUDY

This paper is descriptive with the study mainly carried out in these government hospitals in the Fako Division and it will mainly investigate some main variables like gender difference in the prevalence of HIV/AIDS and factors that lead to the gender disparity in the prevalence of this disease especially among patients in these two major hospitals in a Fako Division in the South West Region of Cameroon.

3.1. STUDY POPULATION

The study population will consist of women living with HIV/AIDS and head of units in the HIV units in the Buea Regional Hospital and the Limbe Regional Hospital all found in the Fako division

3.2. STUDY AREA

This study was carried out in the Regional Hospital, Limbe which is located in the Limbe I Sub-division, Fako Division of the South West Region of Cameroon. This hospital was chosen because it is one of the major referral hospitals in the Southwest Region and also because it is one of the centers of UPEC in the Fako division where I could have access to data on the prevalence. The hospital is made up of a pediatric, internal medicine, surgical, obstetrics and gynecology, theater, intensive care, neonatology and emergency units. The hospital has a well-equipped and up to date laboratory not leaving out the various medical specialists that attend to the patients of this hospital

The Buea Regional Hospital is located in Buea, Fako Division in the South West Region of Cameroon. It is about 2km away from the "Mile 17" bus station, situated between the Catholic School Buea Station and the Army Barracks.

The hospital is made up of several units/departments/centers, which include the Medical Unit, Surgical Unit, Paediatric Unit, Maternity Unit, HIV/AIDS (UPEC) Center, Laboratory Department, X-ray Department, Hemodialysis Center, Tuberculosis Unit, Diabetics/Hypertensive Center, Theatre Department and the Outpatient Department (OPD). Each of the departments/units/centres is headed by a specialist doctor (surgeon, gynaecologist, paediatrician, etc.) but control of the wards is done by ward charges (senior nurses and midwives). Also present in the hospital are nurses of various categories ranging from Nursing Assistants (NAs), State Registered Nurses (SRNs), Higher National Diploma Nurses (HND) and Degree Nurses (BNS). The staff strength of the Buea Regional Hospital as of September 2016, is made up of 176 technical staffs and 62 non-technical staffs giving a total of 238 staffs.

3.3. SAMPLING STRATEGY AND SAMPLE SIZE

The study made use of both purposive and availability sampling technique. The respondents were chosen based on their availability and willingness to participate in the research and purposive sampling technique was also used to choose the areas and places for the study. The population that was used for this study includes HIV positive women and men found in HIV units in the two hospitals. The sample size for the study was 25 female and males HIV/AIDS patients in each of the hospitals.

From the suppose 200 patients that are said to be tested, diagnosed and treated every two months according to initial study by the researcher on trends within five years, the researcher purposively decided to use fifty (50) patients in the both hospital which is 25% representation.

For each of the visits to the two hospitals the first 25 available male and female patients were randomly selected.

Inclusion criteria:

- patients present at the UPEC for collection of ARVs
- the heads of units at the UPEC in the Regional Hospital, Limbe.

Exclusion criteria:

- Denial to participate.

3.4. STUDY APPROACH AND DESIGN

The study adopted a descriptive approach and employed both qualitative and quantitative techniques in data collection and reporting. The research design is therefore the descriptive survey that involves the collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy in procedure, (Kothari, 1985).

3.5. RESEARCH INSTRUMENTS AND PROCEDURES

This study will be done using primary data which involves the use of questionnaires, interviews and observations, collection of data from hospital records and the collection of secondary data from literature reviewed. Research instruments include: Questionnaires and Observation.

➤ Questionnaires

A questionnaire is a research instrument consisting of series of questions and other prompts for the purpose of gathering information from respondents. The questionnaire in this study is made up of both open-ended and closed-ended questions. The aim of the questionnaires is to find out the views of what the selected group of participants think or feel of how they got infected and how they are living with the disease. These questionnaires will be given to Female and male HIV positive people. This is a sample of the questionnaires shared;

➤ Check list

A check is list was used to be write down variables concerning number of women and men infected with this disease in a period of five years retrospectively. It contained sections like the year, the month, the number of men, the number of women, their various percentages and the total number of people. This check list was aimed at determining if the disparity actually exist.

➤ **Observation**

Is a systematic data collection approach that researchers use all their senses to examine people in natural settings or naturally occurring situations? This will help the researcher examine the people on their visit to the center to see if the proportion of man to woman shows a gender difference.

➤ **Data collection**

The study made use of both primary and secondary data. Primary data was collected through the use of structured questionnaire containing close ended questions. The first part of the questionnaire contains questions on the socio-demographic characteristics of the respondents. The second section contains questions on the respondent's perception of the HIV infection. The third section contains questions on teenage sexual knowledge, knowledge on their vulnerability, biological aspects of the sexual organ, knowledge on the prevention HIV/AIDS. The fourth section contains questions on the socio-economic, socio-cultural, educational and political aspects that increase women's vulnerability. A total of 50 questionnaires will be administered. Secondary data will be obtained through journal articles, published and unpublished thesis, magazine articles, web sites publications etc.

➤ **Data management**

The study employed both descriptive and inferential statistics in analyzing the quantitative data from the structured questionnaire. Descriptive statistics included frequency, percentages, mean and standard deviation. Inferential statistics included chi square statistics and Pearson's correlations coefficients. The analysis was carried using Statistical Package for Social Sciences (SPSS) version 20. Charts and tables were used to enhance illustrations. These charts and tables were developed using Microsoft Excel 2013.

➤ **Validation of the Results**

The study took the following steps to ensure the validity of the results. The data collection instruments (questionnaires and interview guides) were tested for reliability prior to the study. The questionnaires and interview were pre-tested in

the in the Limbe regional hospital and Buea regional hospital. At the end of this pre-test, some questions were added, some rephrased to reduce ambiguity, while others were discarded completely. The trustworthiness of the individual's response was also ensured. To do this, cross reference questions were included in the questionnaires and triangulation were extensively done.

Finally, all statistical procedures were reported at the 95% confidence interval or 0.05 significance level. At this margin of error, the findings of the study can be easily generalized to the entire population.

3.6. ETHICAL CONSIDERATIONS

Firstly, the study considered the issue of informed consent. The researcher ensured that the respondents made their decisions without any coercion whether or not to participate in the study based on adequate knowledge of the study. The researcher ensured that the respondents were informed verbally on the instrument of data collection (questionnaire) and on the purpose of the research.

The second ethical issue in the study is that of confidentiality and anonymity. By confidentiality the researcher ensured that just the relevant data to the research was collected. It was explained verbally by the researcher and on the questionnaires that all the information requested for and provided was to be used strictly for academic purposes and kept confidential. Also, the questionnaires were anonymous i.e. the individual identities were not collected such as name, address etc.

Also, in other to carry out the research, an authorization for research was obtained from the Head of Department of Nursing, University of Buea which enabled the researcher to be recognized as a part of the aforementioned institution. An authorization to carry out the research was also obtained from the Regional Delegation of Public Health as well as the Directors of the Regional Hospital, Limbe and the Regional Hospital, Buea which enabled the researcher to be recognized in the hospital in the course of the study.

4. PRESENTATIONS AND ANALYSIS OF DATA

A. Socio-demographic characteristics of respondents

Location

As shown in Table 1, 25 (50%) of the 50 respondents who constituted the study were from Buea and 25 (50%) were from Limbe.

Table 1: Location of respondents

	Frequency	Percent	Valid Percent	Cumulative Percent
Limbe	25	50.0	50.0	50.0
Buea	25	50.0	50.0	100.0
Total	50	100.0	100.0	

Source: Field Work (2017)

Gender of respondents

As shown in Table 2, 15 (30%) of the 50 respondents who constituted the study were male while the others (35 or 70%) were female.

Table 2: Gender of respondents

	Frequency	Percent	Valid Percent	Cumulative Percent
Male	15	30.0	30.0	30.0
Female	35	70.0	70.0	100.0
Total	50	100.0	100.0	

Source: Field Work (2017)

Age of respondent

As shown in Table 3, the average age of the respondents were 33.26 (±12.980) years. The minimum and maximum ages were 19 and 68 years respectively.

Table 3: Age statistics of respondents

Mean	33.26
Std. Deviation	12.980
Minimum	19
Maximum	68

Source: Field Work (2017)

Level of education

As shown in table 4 (2%) out of the 50 student had no formal schooling, 16 (32%) had primary level education, 11 (22%) had secondary level education while the rest (22 or 44%) had university level education.

Table 4: Level of education of respondents

	Frequency	Percent	Valid Percent	Cumulative Percent
No schooling	1	2.0	2.0	2.0
Primary	16	32.0	32.0	34.0
Secondary	11	22.0	22.0	56.0
University	22	44.0	44.0	100.0
Total	50	100.0	100.0	

Source: Field Work (2017)

Occupation

The occupation types of the 40 (80%) of the respondents who reported their occupational status.

Out of the 40 respondents, 8 (20%) were involved in business, 5 (12.5%) were farmers, 1 (2.5%) was a bike rider, 1 (2.5%) was an apprentice, 6 (15%) were housewives, 4 (10%) were teachers or lecturers, 1 (2.5%) was a hairdresser, 1 (2.5%) was a police officer, 4 (10%) were nurses, 1 (2.5%) was a seamstress, 6 (15%) were students and 2 (5%) were secretaries. Source: Field Work (2017)

Income level

As shown in Table 5, 19 (38%) of the respondents earned below 50,000 FRS, 20 (40%) earned 50,000 and 100,000 FRS and 17 (22%) above 100,000 FRS.

Table 5: Level of Income of respondents

	Frequency	Percent	Valid Percent	Cumulative Percent
<50,000	19	38.0	38.0	38.0
50000 -100.000	20	40	40.0	78.0
>100000	17	22.0	22.0	100.0
Total	50	100.0	100.0	

Source: Field Work (2017)

Marital status

As shown in Table 6, 23 (46%) of the respondents were married while the rest (27 or 54%) were single. Among the 11 married respondents who reported their marital regimes, 5 (45.5%) were monogamist and 6 (55.5%) were polygamist.

Table 6: Marital status of respondents

	Frequency	Percent	Valid Percent	Cumulative Percent
Married	23	46.0	46.0	46.0
Unmarried	27	54.0	54.0	100.0
Total	50	100.0	100.0	

Source: Field Work (2017)

Religion of respondents

As shown in Table 7, 20 (40%) of the respondents were Catholics, 3 (6%) were Muslims, 9 (18%) were protestants, 17 (34%) were Pentecostal and 1 (2%) was of the Baha'i faith.

Table 7: Religion of respondents

	Frequency	Percent	Valid Percent	Cumulative Percent
Catholic	20	40.0	40.0	40.0
Muslim	3	6.0	6.0	46.0
Protestant	9	18.0	18.0	64.0
Pentecostal	17	34.0	34.0	98.0
Bahai	1	2.0	2.0	100.0
Total	50	100.0	100.0	

Source: Field Work (2017)

B. Findings of the Study

Perceptions of gender disparity in HIV/AIDS prevalence

Among the 46 (92%) of the 50 respondents who expressed their opinion on the gender disparity in HIV/AIDS prevalence, 6 (13%) were of the opinion that gender disparity in HIV/AIDS prevalence is 100% women, 9 (19.5%) argued that it was 50% women and 50% men, 5 (10.9%) argued that it was 25% women and 75% men and 26 (56.6%) argued that it was 25% men and 75% women (Table 8)

Table 8: Perception of gender disparity in the prevalence of HIV/AIDS

	Frequency	Percent	Valid Percent	Cumulative Percent
100% women	6	13.0	13.0	13.0
50% Women	9	19.5	19.5	32.5
25% women	5	10.9	10.9	43.4
25% men	26	56.6	56.6	100.0
Total	46	92.0	100.0	

Source: Field Work (2017)

A Fisher’s exact test showed statistically significant but weak positive relation between perception of gender disparity and location of respondents ($p=0.02$; $r=0.486$). Most (36.9%) of the respondents in Buea were of the opinion that the gender disparity in HIV/AIDS prevalence is 25% men and 75% women as compared to respondents from Limbe.

Similarly, statistically significant and weak positive association were observed between perception of gender disparity in HIV/AIDS and religion of respondents ($p=0.02$; $r=0.200$).

Trend of the gender proportion of HIV/AIDS prevalence from 2012 to 2017 in Limbe regional hospital. Shows from 2012 to 2016, the proportion of female that constituted the total HIV/AIDS infection oscillated between 60 and 70% while that of male oscillated between 30 and 40%. However, during the first quarter of 2017, the female proportion dropped to the 60th and 50th percentile while that of male rose to the 40th and 50th percentile.

As shown in Table 9, a paired sample t-test revealed statistically significant gender differences in the proportion of HIV/AIDS infection in Limbe regional hospital ($t(5) = 6.053$; $p=0.002$).

Table 9: Gender differences in HIV/AIDS infection in Limbe

	Mean	N	Std. Deviation	Mean difference	t	df	Sig.(2-tailed)
Female	62.2023	6	4.93837	24.40000	6.053	5	0.002
Male	37.7977	6	4.93837				

Source: Field Work (2017)

It was observed that female proportion of HIV/AIDS infection was statistically higher than the proportion of male by 24.40% in Limbe.

Trend of the gender proportion of HIV/AIDS prevalence from 2012-2017 in Buea regional hospital shows from 2012 to 2016, the proportion of female that constituted the total HIV/AIDS infection oscillated between 65 and 75% while that of male oscillated between 25 and 35%.

As shown in Table 10, a paired sample t-test revealed statistically significant gender differences in the proportion of HIV/AIDS infection in Buea regional hospital ($t(5) = 13.74$; $p=0.000$).

Table 10: Gender differences in HIV/AIDS infection in Buea

	Mean	N	Std. Deviation	Mean difference	t	Df	Sig.(2-tailed)
Female	69.60	6	3.49	39.21	13.74	5	0.000
Male	30.39	6	3.49				

Source: Field Work (2017)

It was observed that female proportion of HIV/AIDS infection was statistically higher than the proportion of male by 39.21% in Buea.

Determinants of the prevalence of HIV/AIDS

Biological determinants

Age at first sex

As shown in Table 9, the mean age at first sexual activity was 13.78 (± 2.925) years. The median and modal age at first sex was 13 years and 12 years respectively.

Table 9: Respondents perception of age at first sexual activity

Mean	13.78
Median	13.00
Mode	12
Std. Deviation	2.925
Minimum	11
Maximum	20

Source: Field Work (2017)

Appropriate age for first sexual activity

As shown in Table 10, the appropriate mean age for first sexual activity was reported as 19.82 (±2.038) years. The median and modal appropriate age for first sexual activity were 20 years

Table 10: Perceptions on the most appropriate age for first sexual activity

Mean	19.82
Median	20.00
Mode	20
Std. Deviation	2.038
Minimum	15
Maximum	25

Source: Field Work (2017)

STIs
For sexually transmitted disease, 41 (82%) reported that they have suffered from a sexually transmitted infection while the rest (9, 18%) have not and shows extent of sexually transmitted infections among study respondents

Prevalence of multi-partner relations among young people

Among the 47 respondents who expressed an opinion on the sexual behaviors of young people, 46 (97.8%) reported that youths have multiple sex partners while 1 (2.2%) did not (Table 4.11).

Table 11: Perception of multiple sexual partners relationship among young people

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	46	97.8	97.8	97.8
No	1	2.2	2.2	100.0
	47	100.0		

Source: Field Work (2017)

No statistical significant association was observed between perception of youth multi sexual partner relationship and respondents location (p=0.734), level of education (p=0.503), age group (p=0.863), income level (p=0.303), occupation (p=0.975), marital status (p=0.734) and religion (p=0.848).

Socio-economic determinants

Table 4. Gender of respondents * Level of Income Cross tabulation

		Level of Income				Total
		<10000	>50000	100000	>100000	
Gender of respondents	Male	3	4	4	4	15
	Female	16	16	2	1	35
Total		19	20	6	5	50

Source: Field Work (2017)

Listen to news on TV and Radio

Seventeen (34%) of the respondents listen to news on TV and radio while the rest (33 or 66%) do not listen to the news.

Table 15: Listen to the news on TV and radio

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	17	34.0	34.0	34.0
No	33	66.0	66.0	100.0
Total	50	100.0	100.0	

Source: Field Work (2017)

Listening to the radio was statistically and weakly associated with the respondent's location (p=0.001; r=0.487). Respondents from Buea were more likely to listen to news on TV and radio than the respondents from Limbe.

Travelled out of country

Out of the 50 respondents, 21 (42%) had travelled out of the country while the rest (29 or 58%) had not (Table 16)

Table 16: Travelled out of the country

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	21	42.0	42.0	42.0
No	29	58.0	58.0	100.0
Total	50	100.0	100.0	

Source: Field Work (2017)

No statistically significant associations were found between travelled out of the country and respondents location ($p=0.890$), level of education ($p=0.601$), age group ($p=0.056$), income level ($p=0.065$), occupation ($p=0.211$), marital status ($p=0.145$) and religion ($p=0.225$).

Socio-cultural determinants

Use of contraceptives

Among the 44 respondents that reported their condom usage behavior, 21 (47.7%) reported using contraceptives while the rest (23 or 52.3%) do not (17).

Table 17: Do you use condoms during intercourse

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	21	47.7	47.7	47.7
No	23	52.3	52.3	100.0
Total	44	88.0	100.0	

Source: Field Work (2017)

Use of contraceptives was significantly and weakly associated with location ($p=0.03$; $r=0.319$), age of respondent ($p=0.024$; $r=0.239$) and marital status ($p=0.035$; $r=0.319$).

No significant association was found with the respondents' gender ($p=0.899$), level of education ($p=0.135$), level of income ($p=0.107$), occupation ($p=0.824$) and religion ($p=0.831$).

Traditional practices related to sexual organs

As shown in Table 20 (40%) of the respondents had engaged in some traditional practices related to their sexual organs, 4 (8%) had not while 26 (48%) expressed no opinion on the question.

Table 18: Traditional practices related to sexual organs

	Frequency	Percent	Valid Percent	Cumulative Percent
No	4	8.0	8.0	8.0
Yes	20	40.0	40.0	48.0
No response	26	52.0	52.0	100.0
Total	50	100.0	100.0	

Source: Field Work (2017)

Involvement in traditional practices related to sexual organs was significantly and weakly associated with religion ($p=0.003$; $r=0.153$). More Catholics and Protestants had engaged in those traditional practices than Pentecostals.

No significant association was found between respondents location ($p=0.712$), level of education ($p=0.340$), age group ($p=0.344$), income level ($p=0.746$), occupation ($p=0.184$) and marital status ($p=0.705$).

Among the 20 who had engaged in those practices, 12 (60%) had been to a marabout, 3 (15%) had been involved in circumcision while 5 (25%) had been involved in scarification (Figure 4.3).

Political determinants

Government effort to reduce prevalence of HIV/AIDS

As shown in Table 4.19, among the 50 respondents, 33 (68%) strongly agreed (11, 22%) and agreed (23, 46%) that government is putting in effort to reduce the prevalence of HIV/AIDS while 16 (32%) disagreed (12, 24%) and strongly disagreed (4, 8%).

Table 19: Government is making effort to reduce HIV/AIDS prevalence

	Frequency	Percent	Valid Percent	Cumulative Percent
Strongly Agree	11	22.0	22.0	22.0
Agree	23	46.0	46.0	68.0
Disagree	12	24.0	24.0	92.0
Strongly disagree	4	8.0	8.0	100.0
Total	50	100.0	100.0	

Source: Field Work (2017)

No statistically significant association ($p>0.05$) was observed between government effort to reduce HIV/AIDS prevalence and respondents location, gender, level of education, income level, age group, occupation, marital status and religion.

Government efforts to ensure gender parity in rights to opportunities

As shown in Table 20, 11 (22%) of the 50 respondents strongly agreed (4, 8%) and agreed (7, 14%) that government is putting in effort to ensure that men and women have the same power to enjoy some opportunities in the society while 39 (78%) disagreed (17, 34%) and strongly disagreed (22, 44%).

Table 20: Government efforts to ensure gender parity in rights to opportunities

	Frequency	Percent	Valid Percent	Cumulative Percent
Strongly Agree	4	8.0	8.0	8.0
Agree	7	14.0	14.0	22.0
Disagree	17	34.0	34.0	56.0
Strongly disagree	22	44.0	44.0	100.0
Total	50	100.0	100.0	

Source: Field Work (2017)

Possible measures to be taken to reduce prevalence of HIV/AIDS

Table 4 shows the various measures that can be taken to reduce the prevalence of HIV/AIDS.

4: Measures to reduce the prevalence of HIV/AIDS.

According to 17 (34%) of the respondents, measures should be taken to ensure that women and girls have adequate access to sexual and reproductive health services and that there's equality in the provision of drugs for HIV and opportunistic diseases and palliative care.

Thirty eight (76%) of the respondents proposed that senior health planners, managers and services providers should be sensitized to create a willing and supportive environment for the necessary reforms leading to gender equality in the health sector.

Forty one (82%) of the respondents suggested that young people should have sessions where they are taught on their sexuality and how to manage it.

According to 31 (62%) of the respondents, employment opportunities for women should be increased to improve on their economic levels.

Also, 36 (72%) of the respondents proposed that educational programs should be implemented to create awareness among people on the means of transmission and methods of prevention of the disease.

Furthermore, 35 (70%) advised that new laws should be enacted to deal with issues raised by the disease such as right to confidentiality, protection of employment, sickness rights etc.

Finally, 38 (76%) further cautioned that women should be made to have full and equal rights over their property, marriage, employment etc. like men.

This covers discussions on the major findings of the study conclusion and recommendations. The purpose of the study has been to explore the factors that influence gender disparities in the prevalence of HIV/AIDS in the Limbe regional hospital and Buea regional hospital. In the discussions specific objectives are justified and the researcher has addressed various suggestions in order to know how to remedy this problem

IS THERE A GENDER DISPARITY IN THE PREVALENCE OF HIV/AIDS?

Results show that there is a gender disparity in the prevalence of HIV/AIDS. There are more women infected

with this disease than men. This gender disparity is influenced by some factors which makes women more vulnerable to this disease than men. And I think this is true because as one of the tools of my research I observed that during my visits to administer questionnaires that there were more women present on each visit than men. Regardless of the fact that the man-to-woman ratio is 100:97.5 the gap of the prevalence between men and women is wide. Through examining the extent to which there is a gender disparity, my findings showed that 30% of the 50 respondents who constituted the study were male while the others 70% were female. Secondly Among the 92% of the 50 respondents who expressed their opinion on the gender disparity in HIV/AIDS prevalence, 6 (13%) were of the opinion that gender disparity in HIV/AIDS prevalence is 100% women, 9 (19.5%) argued that it was 50% women and 50% men, 5 (10.9%) argued that it was 25% women and 75% men and 26 (56.6%) argued that it was 25% men and 75% women (Table 8), As shown in Table 9, a paired sample t-test revealed statistically significant gender differences in the proportion of HIV/AIDS infection in Limbe regional Hospital. It was observed that female proportion of HIV/AIDS infection was statistically higher than the proportion of male by 24.40% in Limbe.

As shown in Table 10, a paired sample t-test revealed statistically significant gender differences in the proportion of HIV/AIDS infection in Buea regional hospital ($t(5) = 13.74; p = 0.000$). It was observed that female proportion of HIV/AIDS infection was statistically higher than the proportion of male by 39.21% in Buea. This findings are linked to the study carried out by Nsagha DS, et al. 2010 that indicated similarly that there is a gender disparity in the prevalence of HIV/AIDS and that Africa is losing its power to protect young and potential young girls

DISCUSSION OF FINDINGS OF THE FACTORS THAT INFLUENCE GENDER DISPARITY IN THE PREVALENCE OF HIV/AIDS?

With the analysis different factors were seen to influence gender disparities in the prevalence of HIV/AIDS so the Alternative hypothesis 2 was upheld and the null was rejected. It was seen that level of education, unemployment and low income jobs, marriage (polygamy), early onset of sexual activity, lack of sex education, vaginal and STIs, traditional practices, use of condom, inadequate information, migration.

➤ LACK OF EDUCATION

Many young girls lack the opportunity to go to school right to the university level and this has made them less informed and have a low ability to make strong and personal decisions for themselves, also they are less informed on sex education and the use of contraceptives. From findings of research shown in table 4.4, 1 (2%) out of the 50 student had no formal schooling, 16 (32%) ended at primary level education, 11 (22%) ended at secondary level education while the rest (22 or 44%) had university level education.

From this findings we see that more of the people were found ending at secondary school and since more of the respondents were seen to be women it shows that education influences the ability of a woman to protect herself from this infection. This is similar to what Over (1997) and Lachaud (2007) indicated in their study, which explained that actually education can be a factor that exposes them more to virus infection, as it goes hand in hand with higher socio-professional category. However, as the epidemic spread out the proportion of infected people among educated people is expected to be lower than in the rest of the population. This can be due to many reasons; first, educated people are better informed about prevention measures. Like access to health care, access to education is a means of being informed on prevention methods, especially if educative programs include sexual education.

➤ UNEMPLOYMENT AND LOW INCOME MAKING JOBS

Unemployment among women is higher than among men this is because men attain higher levels of education than women, also some cultures consider women as those who should stay at home and take care of the home while the men go to school, get a job and make money for the family. So women are unemployed and are totally dependent on men for everything which reduces the rights, decision making power etc and exposes them to the infection. From findings of this research 15% of respondents were students, 2% were apprentices, 2% were bike riders, 20% were business people, 12% were farmers, 3% were hair dressers, 15% were housewives, 10% were teachers, 10% nurses, 3% were police, 5% were secretaries and 3% seamstress so summarily 60% of the respondents had low income making jobs, out of the 50 respondents 20 females fell under either doing nothing or under low income making jobs.

This is similar to the findings of Stillwaggon (2002) which indicated that as a result of unemployment, low income making jobs which lead to poverty and poverty influences the gender disparity in that there is lack adequate information, Poverty also impacts on HIV transmission through less access to health services. People are also biologically more vulnerable to HIV infection when they are malnourished and/or experience parasitic infections (that weakens immune system), two features that are more prevalent among poor people.

POVERTY

Poverty is closely related to unemployment and education. With no education you cannot get a well-paid job and there poverty sets in. In order to make money women may have to engage themselves in dangerous sexual activities which exposes them to infection, poverty also reduces access to information and health services. From findings in Table 4.5,

19 (38%) of the respondents earned below 50,000 FRS, 20 (40%) earned 50,000 and 100,000 FRS and 17 (22%) above 100,000 FRS, 16 women earned less than 10000frs while 3 men earned less than 10000frs, out of the female respondents 30 fell under the lower income levels and, and the males fell under the higher income levels.

This is linked to the study carried out by Cohen, 1998 which indicates that poor households typically have few financial or other assets and are often politically and socially marginalized. These conditions of social exclusion increase the problems of reaching these populations through programmes aimed at changing sexual and other behaviors. Thus they tend to lack adequate information. Poverty also impacts on HIV transmission through less access to health services.

➤ MARRIAGE AND POLYGAMY

Marriage is seen as a possible factor because if the man who is seen to be more promiscuous than the woman has other sexual partners out of marriage therefore the woman is exposed to whatever her husband brings in to their home from his other sexual relationships which can be HIV/AIDS. Also, in a polygamous home if one person gets infected the other wives are exposed to this infection through their husband, here there is one man but several women. From findings of this research in Table 6, 23 (46%) of the respondents were married while the rest (27 or 54%) were single. Among the 11 married respondents who reported their marital regimes, 5 (45.5%) were monogamist and 6 (55.5%) were polygamist. This findings are linked to a study carried out by Couderc N., Ventelou, B. (2005) which indicated that Marriage and polygamy have influenced the transmission of this infection

EARLY ONSET OF SEXUAL ACTIVITY

Many youths get sexually active at ages between 12-18 and at this age the sexual organ of a girl is not well developed and this leads to tearing during sex exposing them to the virus. Also at this young age many don't have adequate information for their sexual life and cannot handle it with maturity. From findings shown in Table 9, the mean age at first sexual activity was 13.78 (± 2.925) years, As shown in Table 10, the appropriate mean age for first sexual activity was reported as 19.82 (± 2.038) years. This is similar to a study carried out by Matlin S and Spence N, 2000 which indicated that this variable is thought to favor the epidemic mainly through girls' age at the first sexual intercourse. The younger they begin sexual activity, the more they are exposed to tearing, since their partners are almost always older and their body is still immature. More importantly, many people aged less than 15 have not received enough formal sexual education to use condoms. This sexual education is rather learned in the street, with all what it embodies as misinterpretations and generally accepted ideas.

➤ LACK OF SEX EDUCATION AND ACCESS TO INFORMATION

Sex education is very important, to teach young people about their sexual lives; how to initiate, precautions to take and how to protect themselves from infection. It is seen that most young people do not participate in sexual education session. From findings, Seventeen (34%) of the respondents listen to news on TV and radio while the rest (33 or 66%) do

not listen to the news. This ties with this study by the Demographic Health Survey/AIDS in 2001 which stated that many infections occurred because people were not even aware of the virus existence and most still occur because they are not informed appropriately about transmission modes and preventive measures (sex education). While awareness of the epidemic is on the rise, specific knowledge about HIV is still inadequate. Although efforts are increasingly made to sensitize populations and especially young people about the pandemic, there are persistent misconceptions about how HIV is transmitted.

➤ **SEXUALLY TRANSMITTED INFECTIONS**

STIs in women are less noticed and often go undiagnosed. The stigma of STIs in women also presents a barrier that discourages them from accessing adequate treatment which increases the chances of them being infected. From findings shown in Figure 4.2, 41 (82%) reported that they have suffered from sexually transmitted infections while the rest (9, 18%) have not and among the respondents who reported 32 (64%) were female. (Table 11),

This is linked to studies carried out by Bouhnik et al., 2002 which indicated that Sometimes women's vaginal bacteria changes, lowering the levels of normal flora and increasing harmful bacteria, which can increase the risk of HIV infection 2.5 times. Men and women's risks of acquiring HIV escalate in the presence of Sexually Transmitted Infections (STIs).

➤ **MULTIPLE SEXUAL PARTNERS**

One of the factors that this gender difference is that men expose themselves to an increased risk of infection by having multiple partners, and in turn become the vector for transmission of HIV/AIDS to their partners, even if the women themselves are not behaving promiscuously. Even the women themselves engage in multiple sexual partners in search of money which exposes them to this disease. From findings of this research, among the 47 respondents who expressed an opinion on the sexual behaviors of young people, 46 (97.8%) reported that youths have multiple sex partners while 1 (2.2%) did not. Out of the 50 respondents, this finding is linked to a study by Spiegel P, Harroff-Tavel H, 2006 which brought out the fact that there is a large difference in attitudes towards men's and women's sexuality before or outside marriage. Promiscuity in men is often condoned and sometimes encouraged, while it is usually frowned upon in women

➤ **MOBILE POPULATION**

When business people and other travelers go out of their country and leave their partners behind and in order to satisfy their sexual desires they go in for some commercial sex workers who may and may not be infected. After this brief relationships they either pick up an infection or transmit it and here the women who can easily pick it it is more exposed. From findings shown on table 16 21 (42%) had travelled out of the country while the rest (29 or 58%) had not. This is linked studies by Greene, 2000 indicating that migrant workers form an important part of labor force in poor countries. Industrial and mining projects are almost located in remote areas where workers cannot see their regular partners for a long time. Commercial sex develops in these areas for economic reasons. Generally, neither sex workers nor their clients are aware of their serologic status.

➤ **USE OF CONDOM**

Condom is used to protect ourselves from infection and women have a low decision making power in negotiating the use of condom and are therefore more exposed. From findings of this study among the 44 respondents that reported their contraceptive usage behavior, 21 (47.7%) reported using condom while the rest (23 or 52.3%) do not (Table 4.17). This agrees with study carried out by Pinkerton and Abramson (1997) which states that some partners do not negotiate the use of condom which is more detrimental to the woman. Latex condoms provide protection against HIV transmission to both partners and reduce the impact of cofactors such as genital ulcers and other STDs. Thus, WHO recommends condom as the only contraceptive that also protects from HIV/AIDS when used efficiently. The Centre for Disease Control and Prevention (CDC, 1999) warns that only latex or polyurethane condoms provide a highly effective mechanical barrier to HIV.

➤ **TRADITIONAL PRACTICES**

Traditional practices carried out on girls like genital mutilation which exposes them to this disease and from findings of the research shown in Table 4.18, 20 (40%) of the respondents had engaged in some traditional practices related to their sexual organs, 4 (8%) had not while 26 (48%) expressed no opinion on the question. This agrees with studies by Auvert et al., 2005. which indicates that male circumcision, which is common to many African customs and compulsory in Muslim religion, has a demonstrated impact on HIV transmission but women's genital mutilation problem is more serious.

➤ **GOVERNANCE**

The government has a vital role to play that the employment opportunities are created by the government and also health and sex education programs are organized by the government. From findings shown in Table 4.19, among the 50 respondents, 33 (68%) strongly agreed (11, 22%) and agreed (23, 46%) that government is putting in effort to reduce the prevalence of HIV/AIDS while 16 (32%) disagreed (12, 24%) and strongly disagreed (4, 8%). It is seen that according to some respondents opinion the government is doing much and others disagree with that. This is linked to study carried out by Bonnel (2000), which states that Its influence on the epidemic goes through the priority government gives to HIV/AIDS as a public health issue of concern. For most African countries, disastrous economic situation is caused more by bad governance than by international adverse conditions. In a corrupted political environment, decision-makers can be not incited to invest enough in HIV/AIDS prevention activities. In that way, good governance appears as a factor of the epidemic's slowing down. Of all the factors low education, multiple sexual partners and early onset of sexual act ranked highest.

4.3. SOME POSSIBLE MEASURES TO CHECK THE DISPARITY IN THE PREVALENCE OF HIV/AIDS

From the analysis some measures can be taken at various levels to check the high prevalence of HIV/AIDS among females thereby reducing the gender disparity. Examples include carrying out sex education programs, increasing health services, sessions to teach people of the importance of the use of condom and how to use it, women empowerment programmes, change of laws that deal with women's rights

etc. below are some findings of this study and how they are linked to previous study

- 35 (70%) of all respondents advised that new laws should be enacted to deal with issues raised by the disease such as right to confidentiality, protection of employment, sickness rights etc. Finally, 38 (76%) further cautioned that women should be made to have full and equal rights over their property, marriage, employment etc. like men, Thirty eight (76%) of the respondents proposed that senior health planners, managers and services providers should be sensitized to create a willing and supportive environment for the necessary reforms leading to gender equality in the health sector.

This findings agree with what Strategies for action (Joint United Nations Program on HIV/AIDS,1999) which stated three points;

1. Urgent review is needed in each country of the legal status of women, to ensure that they have full and equal rights compared with men and that the protection of the law extends to those who become infected, orphaned or widowed as a result of HIV/AIDS.
 2. Sensitization seminars and workshops are needed for the legal profession and law enforcement officers to ensure that the legal provisions for equality are fully implemented.
 3. New laws may need to be enacted that deal with specific problems raised by HIV/AIDS, such as: legal sanctions against persons knowingly infecting others; rights to confidentiality; protection of employment, sickness benefits and pension rights.
- According to 17 (34%) of the respondents, measures should be taken to ensure that women and girls have adequate access to sexual and reproductive health services and that there equality in the provision of drugs for HIV and opportunistic diseases and palliative care.

This also agrees with the 1995 International Conference on STD/AIDS in Kampala, a group of young Africans from 11 countries which put forward a series of principles which they saw as essential for effective AIDS action

1. Youth participation in programme planning, implementation, monitoring and evaluation
 2. Provision of youth friendly services and centers where young people can access information, support and referral
- According to 31 (62%) of the respondents, employment opportunities for women should be increased to improve on their economic levels.

This agrees with studies carried out by Blundell R., Bond S,1998 which stated that positive strategies to assist women who are affected by HIV/AIDS might include the encouragement of informal sector entrepreneurship and micro-credits, as well as community action groups and social welfare support mechanisms.

- Also, 36 (72%) of the respondents proposed that educational programs should be implemented to create awareness among people on the means of transmission and methods of prevention of the disease, Forty one (82%) of the respondents suggested that young people should have sessions where they are taught on their sexuality and how to manage it.

This agrees with studies by Garbus L, 2001 which stated that advocate for improved health education and public awareness and the adoption of all measures that will limit the transmission of the virus including safe sex (increased use of male and female condoms), monogamy and abstinence as appropriate and the use of safe blood products.

5. CONCLUSIONS

This study attempted to examine the fact that the prevalence of HIV/AIDS is higher among females than among males and that there are some factors that influence this disparity among patients in the Limbe Regional Hospital and Buea Regional Hospital. This concluded that, the gender disparity in Limbe regional hospital is 24.40% and in Buea Regional Hospital is 39.21%. Some factors that were seen to influence this disparity were; level of income, marriage(polygamy), level of education, onset of sexual activity, sexually transmitted diseases, multiple sexual partners, sex education, mobile population, use of condom, traditional practices, governance. At a general level The study shows that in these area women have higher risk of being infected with HIV/AIDS compared to men and that apart from biological vulnerability, socio-cultural as well as economic factors accounted for those differences.

Also Possible measures that could be used were; full and equal rights for women, new laws should be enacted, educational programmes should be set up, employment rates for women should be increased, sensitization of senior health planners, adequate access to sexual and reproductive health.

This study has indicated that this disparity is associated with different factors which influence it and impacts on socio-economic development of young women and families. Based on the findings, it can be concluded that there is an incidence of a gender disparity in the prevalence of HIV/AIDS, there are several factors that influence this disparity which include low level education, low use of contraceptives, exposure to explicit sexual content and early engagement in sex. Also high prevalence among females provides greater grounds for the spread and consequently a serious limitation in the fight against the disease.

LIMITATIONS OF THE STUDY

- Some people who struggled with perceived worries about their ill-health were less likely to respond to questionnaires and also some of these possible respondents were shy or ashamed to complete answering the questions. This poses real difficulties in convincing them so the convenient sample was used.

- In all of the hospitals of the study, despite the planned visits the visit to the UPEC centers by the patients on treatment was not the same for all the patients had different rendez-vous

RECOMMENDATIONS

Through the numbers of causes of this gender difference, there are a number of ways in which the gender disparity in the prevalence of HIV/AIDS can be controlled. These ways include; full and equal rights for women, new laws should be enacted, educational programmes should be set up, employment rates for women should be increased, sensitization of senior health planners, adequate access to sexual and reproductive health and sex education, use of contraceptives, prevention programs and abstinence.

TO THE GOVERNMENT, NGO/CSOS, SCHOOL COUNSELORS, PARENTS AND THE YOUTHS THEMSELVES

➤ **Sex Education**

Sex education that is responsible and medically accurate, begins in kindergarten, and continues in an age-appropriate manner through high school is necessary given the early ages at which young people are initiating intercourse — 6.2% of students nationwide report having sex before the age of 13, 43.8 % by grade 10, and 63.1% by the time they are getting to secondary school (CDC, 2012). (Frost & Forrest, 1995). Parents and school take greater steps to involve themselves in early onset of sexual activity prevention

HIV/AIDS Prevention Programs

Although the government is very involved the current policy needs to be implemented in a more effective manner in a multisectorial approach in order to curb the current trend of the feminization of HIV/AIDS HIV/AIDS Prevention Programs by the government, NGOs and civil society organizations, schools and other stakeholders should have a wide variety of programs developed, with such approaches approaches;

➤ Educational programs for children and adolescents, programs to improve access to contraception, programs geared toward educating parents and family members, multicomponent programs, and youth development programs. Some of these programs receive government funds and meet criteria for abstinence-only education, while others provide a more comprehensive approach and include instruction not only on abstinence but also on contraception, sexuality, sexually transmitted infection prevention, and youth development (abstinence-plus programs).

➤ The use of contraceptives: Develop social media tools and messages to Increase access to contraceptives and health care Contraception simply means using a method (mechanical or chemical) to prevent infection. There are various contraceptives but the one which prevents infection is the male n female condom

The Government and NGOs/CSOs

The government, NGOs/CSOs and other stake holders should promote youth development, and Provide employment for young people particularly the expansion of adolescent skill and life options through varies capacity building activities. Policymakers and program planners seeking to design and implement interventions to reduce the risk of infection by providing employment.

Promote Education for youths beyond Primary Level

Parents, the government NGOS and other stakeholders should promote education beyond primary level, for this is the earliest possible intervention provided to children and young people that can impact on a conception not taking place, it is essential that training is available to parents/careers and professionals to send their children to school. (Fuchs V, 2015.)

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